Slide

Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program

Notes

Instruction

- **Course overview:**
  - **The Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program is an instructor-led course that provides learners with an introduction the Medicare Program. The course is based on information found in the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (hereafter called the *Medicare Physician Guide*).**
- **Audience:**
  - **Medical residents, physicians, and other health care professionals new to the Medicare Program.**
- **Time:**
  - **The delivery time for this course is approximately three hours.**
- **Facilitator preparation notes:**
  - **Verify that the computer and projector operate properly. Adjust the projector to the maximum screen viewing area.**

Slide

Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program

Notes

Instruction

- **Provide each learner with the following course materials:**
  - ***Medicare Physician Guide*** **publication and/or CD-ROM**
  - **Reference Information**
  - **Pre-Assessment package(s) – at beginning of training module(s)**
  - **Post-Assessment package(s) – at conclusion of training module(s)**
  - **Course Evaluation – at conclusion of training module(s)**

Slide

Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program

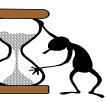
Notes

Instruction

•Icons that prompt the facilitator during the course are:

• Indicates that the facilitator will read aloud

• Indicates that the facilitator will hand out materials



• Indicates the average time it takes to present the training module

• Indicates an important note for the facilitator

A

• Indicates that the facilitator will administer the Pre- or Post-Assessment

?

• Indicates that the facilitator is provided with a question to ask the learners

Slide

Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program

Notes

Instruction

The course learning objectives are:

Chapter 1

- **Identify Medicare's four parts**
- **Recognize the three groups of Medicare insured beneficiaries**
- **Identify the organizations that impact the Medicare Program**
- **Describe recent laws that impact the Medicare Program**

Chapter 2

- **Identify Part A and Part B Medicare providers and suppliers**
- **Describe the Medicare Program enrollment process**
- **Identify how providers and suppliers can protect their practice**
- **Identify how providers and suppliers can promote cultural competency**

Slide

Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program

Notes

Instruction

Chapter 3

• Describe how Medicare providers and suppliers are reimbursed for the items and services they furnish

• Identify when Medicare is the secondary payer

• Recognize physician incentive and bonus payments

Chapter 4

• Determine the services Medicare pays for

• Determine the services that Medicare does not pay for

Chapter 5

• Describe documentation guidelines for residents and teaching physicians

• Identify the seven components that define the levels of evaluation and management

Slide

Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program

Notes

Instruction

Chapter 6

- **Identify the goal of the Medicare Integrity Program**
- **Describe the medical review process**
- **Determine the two types of coverage determinations**
- **Define fraud**
- **Define abuse**
- **Identify the potential legal actions that may be imposed if a provider, supplier, or health care organization has committed fraud and abuse**

Chapter 7

- **Describe how providers and suppliers can find answers to inquiries**
- **Identify the reasons overpayments are often paid**
- **Identify the five levels of the fee-for-service appeals process**
- **Define a reopening**

Slide

Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program

Notes

Instruction

•Welcome to the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program. My name is [insert your name] from [insert name of your organization] and I will be your facilitator today.

•This program has been made available to medical schools and other organizations by the Centers for Medicare & Medicaid Services (CMS). CMS developed this program because we are aware that being a health care professional involves more than what you learn in college or medical school.

• The keys to successful participation in the Medicare Program include having a basic understanding of Medicare's rules and regulations and continuing to stay informed from both a clinical and a business perspective

•Please review your hand outs to check that you have the *Medicare Physician Guide*, Reference Information, and Pre-Assessment package(s). If you don't have all of these materials, please raise your hand.

Slide

Pre-Assessment

8

Notes

Instruction

• The reference information hand out contains some useful documents. These are the glossary and a list of acronyms, helpful websites, and reference materials. These documents can also be found in the back of your *Medicare Physician Guide*.

A

• Please take out the Pre-Assessment(s) package for chapter(s) [insert chapter numbers that you will be presenting].

•The purpose of the Pre-Assessment is to determine your knowledge of the Medicare Program prior to today's program. Please take a few minutes now to take the Pre-Assessment, marking your answers on the answer sheet included in the package.

• Note: Each training module has a separate Pre-Assessment package. Learners should receive the corresponding Pre-Assessment package, depending on which training module(s) you are presenting.

05 3 Hour Medicare Program Training Module
Pre-Assessment

Slide

CHAPTER 1

INTRODUCTION TO THE MEDICARE PROGRAM

Notes

Instruction

- **Chapter One is an introduction to the Medicare Program.**

- **The learning objectives for Chapter One are:**

  - Identify Medicare's four parts
  - Recognize the three groups of Medicare insured beneficiaries
  - Identify the organizations that impact the Medicare Program
  - Describe recent laws that impact the Medicare Program

- **Materials required:**
  - **None**

- **Time required to complete this training module:**
  - **Approximately 30 minutes**

Slide

Introduction to the Medicare Program

- Largest health insurance program
- Over 1 billion claims annually
- Nearly 42 million individuals

10

Notes

Instruction

•The Centers for Medicare & Medicaid Services (CMS), which is an agency within the U.S. Department of Health and Human Services (HHS), administers and oversees the Medicare, Medicaid, and State Children's Health Insurance Programs. It also awards contracts to organizations called Contractors who perform claims processing and related administrative functions.

•Medicare is the nation's largest health insurance program. It processes over one billion claims annually.

•Since nearly 42 million enrollees are entitled to Medicare benefits, it is likely that you will treat and interact with Medicare beneficiaries during your practice. Your actual Medicare patient ratio is dependent upon where your practice is located and your specialty.

Slide

Introduction to the Medicare Program

- Four parts
  - Part A, hospital insurance
  - Part B, medical insurance
  - Part C, Medicare Advantage
  - Part D, prescription drug plan

11

Notes

Instruction

- **Medicare consists of four parts:**
  - **Part A, which is hospital insurance**
  - **Part B, which is medical insurance**
  - **Part C, which is Medicare Advantage and**
  - **Part D, which is the prescription drug plan**

Slide

Part A
Hospital Insurance

- Inpatient hospital care
- Inpatient care in a Skilled Nursing Facility following covered hospital stay
- Some home health care
- Hospice care

12

Notes

Instruction

•**Some of the services that Part A, hospital insurance, helps pay for include:**

- **Inpatient hospital care**
- **Inpatient care in a Skilled Nursing Facility (SNF) following a covered hospital stay**
- **Some home health care and**
- **Hospice care**

Slide

Part A
Hospital Insurance

- Payroll taxes
- Self-employed individual contributions
- Contributions from railroad workers and their employers or representatives

Notes

Instruction

•Part A is financed by:

• Payroll taxes paid by employers and employees through the Federal Insurance Contributions Act

• Self-employed individual contributions through the Self-Employment Contributions Act and

• Contributions from railroad workers and their employers or representatives through the Railroad Retirement Act

Slide

Part B
Medical Insurance

- Physician and practitioner services
- Home health care
- Ambulance services
- Clinical laboratory and diagnostic services
- Surgical supplies
- Durable medical equipment and supplies

14

Notes

Instruction

•Some of the services that Part B, medical insurance, helps pay for include:

• Medically necessary services furnished by physicians in a variety of medical settings

• Services furnished by practitioners with limited licensing

• Home health care

• Ambulance services

• Clinical laboratory and diagnostic services

• Surgical supplies and

• Durable medical equipment and supplies

Slide

Part B
Medical Insurance

- Premium payments
- Contributions from general Federal government revenues
- Interest earned on Part B Trust Fund

15

Notes

Instruction

•**Part B is financed by:**

- **Premium payments by enrollees**
- **Contributions from general Federal government revenues and**
- **Interest earned on the Part B trust fund**

Slide

Part C
Medicare Advantage

- Organizations contract with CMS to provide health care services to beneficiaries
  - Entitled to Part A and enrolled in Part B
  - Permanently reside in service area of Plan
  - Elect to enroll

16

Notes

Instruction

•Part C or Medicare Advantage (MA), previously known as Medicare + Choice, is a program through which organizations that contract with CMS provide or arrange for the provision of health care services to Medicare beneficiaries who:

- **Are entitled to Part A and enrolled in Part B**
- **Permanently reside in the service area of the MA Plan and**
- **Elect to enroll in a MA Plan**

•Individuals with End-Stage Renal Disease (ESRD) are generally excluded from MA Plans.

•CMS generally pays the MA organization a fixed amount, or capitation rate, and the MA organization then reimburses providers and suppliers who participate in the MA Plan(s) offered by the MA organization for services furnished within the terms of the agreement/plan.

05 3 Hour Medicare Program Training Module

Chapter 1

Slide

Part D
Prescription Drug Plan

- Began January 1, 2006
- All who elect to enroll are covered
- Standard coverage or low income subsidies

17

Notes

Instruction

•Part D, the prescription drug plan, provides prescription drug coverage to all beneficiaries who elect to enroll beginning on January 1, 2006.

•Beneficiaries may be eligible for standard coverage or low income subsidies. In 2006, standard coverage includes:

- **•An estimated $32.20 monthly premium**
- **•$250.00 yearly deductible**
- **•25 percent coinsurance up to an initial coverage limit of $2,250 and**
- **•Catastrophic coverage once a beneficiary spends $3,600 of his or her own money out-of- pocket for the year**

Slide

Medicare Eligibility

- Aged Insured
- Disabled Insured
- End-Stage Renal Disease Insured

18

Notes

Instruction

•There are three groups of Medicare insured beneficiaries:

• Aged insured, who are at least 65 years old and eligible for Social Security, Railroad Retirement, or equivalent Federal benefits

• Disabled insured, who are automatically entitled to Part A after receiving Social Security disability cash benefits for 24 months and are enrolled in Part B unless they refuse Part B coverage and

• ESRD insured, who are individuals of any age who in order to maintain life receive regular dialysis treatments or a kidney transplant, have filed an application, and meet one of the following conditions:

•Certain Social Security work requirements or entitled to Social Security benefits

•Eligible under Railroad Retirement Programs or entitled to an annuity under the Railroad Retirement Act or

•Is the spouse or dependent child of an insured individual

Slide

Identifying Beneficiaries

19

Notes

Instruction

•When an individual becomes eligible for Medicare, CMS or the Railroad Retirement Board issues a health insurance card like the one shown on the screen.

•Office staff should regularly request the patient's health insurance card and picture identification to verify that services are furnished only to individuals eligible to receive Medicare benefits. Copies of the health insurance card and picture identification should be made for the patient's medical file. The following information can be found on the health insurance card:

- **Name**
- **Sex**
- **Medicare Health Insurance Claim number and**
- **Effective date of entitlement to Part A and/or Part B**

Slide

Organizations That Impact Medicare

- Social Security Administration
- Office of Inspector General
- Quality Improvement Organizations
- State Health Insurance Assistance Program

20

Notes

Instruction

•There are many organizations that impact the Medicare Program. The Social Security Administration determines eligibility for Medicare benefits and enrolls individuals in Part A and/or Part B and the Federal Black Lung Benefit Program.

•The Office of Inspector General protects the integrity of HHS programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions.

•Quality Improvement Organizations conduct quality improvement projects.

•The State Health Insurance Assistance Program (SHIP) offers free one-on-one counseling and assistance to people with Medicare and their families. Counselors provide a wide range of information about long-term care insurance; Medigap; fraud and abuse; the Medicare and Medicaid Programs; and public benefit programs for those with limited income and assets. There are SHIPs in all 50 states, Washington, D.C., Puerto Rico, and the Virgin Islands.

Slide

Recent Laws That Impact Medicare

- Medicare Prescription Drug, Improvement, and Modernization Act of 2003

21

Notes

Instruction

•The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 provides the most dramatic and innovative changes to Medicare since it began in 1965. The MMA enacted the Medicare prescription drug benefit and numerous contracting reforms. A key aspect of the contracting reforms is that Medicare will begin integrating Fiscal Intermediaries and Carriers into new single authorities called Medicare Administrative Contractors.

•The MMA also extended the moratorium on the financial limitation of outpatient physical therapy, occupational therapy, and speech-language pathology services until December 31, 2005. Unless there is a change in the statute, limitations will apply on January 1, 2006.

Slide

Recent Laws That Impact Medicare

- Health Insurance Portability and Accountability Act of 1996

22

Notes

Instruction

•The Health Insurance Portability and Accountability Act of 1996 was enacted on August 21, 1996 to establish:

- **•National standards for electronic health care transactions and national identifiers for providers, health plans, and employers**
- **•Safeguards to protect the security and privacy of health data**
- **•The Health Care Fraud and Abuse Control Account and**
- **•Health insurance coverage protection for workers and their families when they change or lose their jobs**

Slide

Let's Review

- What are Medicare's 4 parts?
- What are the 3 groups of Medicare insured beneficiaries?

23

Notes

Instruction

- **Let's review the material we covered in this chapter.**

?

- **What are Medicare's four parts?**
  - **Answer –**
    - Part A, hospital insurance
    - Part B, medical insurance
    - Part C, Medicare Advantage
    - Part D, prescription drug plan

?

- **What are the three groups of Medicare insured beneficiaries?**
  - **Answer –**
    - Aged insured
    - Disabled insured
    - End-Stage Renal Disease insured

Slide

CHAPTER 2

BECOMING A MEDICARE PROVIDER OR SUPPLIER

Notes

Instruction

- **Chapter Two discusses how to become a Medicare provider or supplier.**

- **The learning objectives for Chapter Two are:**

  - Identify Part A and Part B Medicare providers and suppliers
  - Describe the Medicare Program enrollment process
  - Identify how providers and suppliers can protect their practice
  - Identify how providers and suppliers can promote cultural competency

- **Materials required:**
  - **None**

- **Time required to complete this training module:**
  - **Approximately 40 minutes**

Slide

Part A

- Critical Access Hospitals
- Home Health Agencies
- Hospice
- Hospitals (acute care inpatient services)
- Skilled Nursing Facilities

Notes

Instruction

•The Medicare Program recognizes a broad range of providers and suppliers who furnish necessary services and supplies to meet the health care needs of beneficiaries.

•Medicare makes payment under Part A for certain services furnished by the following types of entities (this is not an all-inclusive list):

- **•Critical Access Hospitals**
- **•Home Health Agencies (including sub-unit)**
- **•Hospice**
- **•Hospitals (acute care inpatient services) and**
- **•Skilled Nursing Facilities (SNF)**

Slide

Part B

- Ambulatory Surgical Centers
- Durable medical equipment
- End-Stage Renal Disease facilities
- Hospitals (outpatient)
- Physicians
- Skilled Nursing Facilities (outpatient)

Notes

Instruction

•Services provided by the following are paid under Part B (this is not an all-inclusive list):

•Ambulatory Surgical Centers

•Durable medical equipment, prosthetics, orthotics, and supplies suppliers (including pharmacies)

•End-Stage Renal Disease Facilities

•Hospitals (outpatient services)

•Physicians and

•SNFs (outpatient services)

Slide

Medicare Physician

- Doctors of medicine and osteopathy, dental surgery or dental medicine, podiatry or surgical chiropody, optometry
- Chiropractors

Legally authorized to practice by state

Notes

Instruction

•The Medicare Program defines physicians to include the following:

•Doctors of medicine and osteopathy

•Doctors of dental surgery or dental medicine

•Chiropractors

•Doctors of podiatry or surgical chiropody or

•Doctors of optometry

•In addition, the Medicare physician must be legally authorized to practice by a state in which he or she performs this function.

Slide

Interns and Residents

- Participate in approved postgraduate medical training programs
- Not in approved programs, but authorized to practice only in hospital setting

Notes

Instruction

•Interns and residents include physicians who participate in approved postgraduate medical training programs or are not in approved programs, but are authorized to practice only in a hospital setting.

•Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services.

Slide

Teaching Physician

- Involves residents in the care of his/her patients
- Present during all critical and key portions of procedure and immediately available to furnish services during entire service

Notes

Instruction

•A teaching physician is a physician (other than an intern or resident) who involves residents in the care of his or her patients.

•Generally, the teaching physician must be present during all critical and key portions of the procedure and immediately available to furnish services during the entire procedure in order for it to be payable under the Medicare Physician Fee Schedule (MPFS).

Slide

Medicare Practitioner

- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse midwife
- Clinical psychologist
- Clinical social worker
- Registered dietician/nutrition professional

Notes

Instruction

•Medicare defines a practitioner as any of the following to the extent that he or she is legally authorized to practice by the state and otherwise meets Medicare requirements:

•Physician assistant

•Nurse practitioner

•Clinical nurse specialist

•Certified registered nurse anesthetist

•Certified nurse midwife

•Clinical psychologist

•Clinical social worker or

•Registered dietician or nutrition professional

Slide

Enrolling in Medicare

- Include with Form CMS-855
  - Forms CMS-588 and CMS-460
  - Electronic Interchange Agreement
  - State medical license
  - Occupational or business license
  - Certificate of Use

31

Notes

Instruction

•To obtain reimbursement from Medicare, providers and suppliers must first enroll in the program by completing the appropriate Form CMS-855, the Provider/Supplier Enrollment Application.

•The following forms are often required in addition to the CMS-855 form:

•Form CMS-588, the Medicare authorization agreement for electronic funds transfers

•Form CMS-460, the agreement to become a Part B participating provider or supplier

•Electronic Interchange Agreement

•State medical license

•Occupational or business license and

•Certificate of Use

•You can find the Centers for Medicare & Medicaid Services (CMS) enrollment and agreement forms on the CMS website. After all forms have been completed and signed, the packet is then mailed to the appropriate Medicare Contractor for processing. For most applicants, the enrollment process takes 60 days.

05 3 Hour Medicare Program Training Module

Chapter 2

Slide

National Provider Identifier

- Standard unique identifier
- Required by May 23, 2007 or May 23, 2008
- Replaces health care provider identifiers now used

32

Notes

Instruction

•Upon acceptance into the Medicare Program, providers and suppliers are assigned certain identification numbers.

•A standard unique identifier for health care providers, suppliers, health plans, and organizations called the National Provider Identifier (NPI) must be accepted and used by all Health Insurance Portability and Accountability Act-covered entities in standard transactions by May 23, 2007 or May 23, 2008 for small health plans.

•The NPI will replace health care provider identifiers that are now being used in standard transactions including Provider Identification Numbers (PIN), Unique Physician/Practitioner Identification Numbers (UPIN), Online Survey Certification and Reporting numbers, and National Security House numbers. Obtaining an NPI does not eliminate Medicare enrollment requirements for providers and suppliers who wish to serve beneficiaries.

Slide

Provider Identification Number

- Identifies who furnished service
- Needed to receive payment
- Required on all claims

33

Notes

Instruction

- **A PIN is an individual billing number that:**
  - **Identifies who furnished services to the beneficiary on the Medicare claim form**
  - **Allows providers and beneficiaries to receive payment for claims filed to the Medicare Contractor**
  - **Is required on all claims submitted to the Contractor; an "unprocessable" claim denial will result if a PIN is not included in the appropriate claim block or claim field and**
  - **Is issued by the Contractor**

Slide

Unique Physician/ Practitioner Number

- National, permanent number
- Identifies ordering or referring physician/practitioner

34

Notes

Instruction

•A UPIN is an individual identification number that is:

•A national number used to identify physicians and practitioners who order or refer services

•A permanent number that may be used in any state where they practice

•Received by all physicians and practitioners enrolled in Medicare who order or refer services even though they might never bill Medicare directly

•Received by individual physicians and practitioners (one number is assigned regardless of the number of practice settings)

•Assigned by CMS and

•Required for consultations, routine foot care, durable medical equipment, orthotic/prosthetic devices, most diagnostic services, services by independently-practicing physical therapists and occupational therapists, and any other service that is ordered or referred

Slide

Participating Provider/Supplier

- Accepts assignment
- One year participation period

35

Notes

Instruction

•There are two types of providers and suppliers in Part B of the Medicare Program: participating and nonparticipating. First we will discuss participating providers and suppliers. When you complete and sign Form CMS-460, you have formally notified CMS that you wish to participate in the Medicare Program and will accept assignment of benefits for all covered services for all Medicare patients.

•Assignment means that you will be paid the Medicare allowed amount as payment in full for your services.

•Participation is for a yearlong period from January 1 through December 31. Active participants receive a participation package during the Contractor Open Enrollment Period, which is usually in November. During this period, you can change your participation status for the following year. If you wish to continue participating, you do not need to sign an agreement each year.

Slide

Participating Provider/ Supplier Benefits

- Higher Medicare Physician Fee Schedule allowances
- No limiting charge provisions
- Medicare Participating Physician and Supplier Directory

36

Notes

Instruction

- **As a participating provider or supplier, you will receive the following benefits:**
  - **Five percent higher MPFS allowances**
  - **Limiting charge provisions are not applicable and**
  - **Included in the Medicare Participating Physician and Supplier Directory**

05 3 Hour Medicare Program Training Module
Chapter 2

Slide

Medicare Physician Fee Schedule

- Medicare allowed amounts
- Updated annually
- 3 factors
  - Relative Value Unit
  - Geographic adjustment factor
  - Nationally uniform conversion factor

37

Notes

Instruction

•Medicare allowed amounts can be found in the MPFS, which is updated annually based on a formula defined by Medicare law and through a formal rulemaking proceeding.

•The payment amount for each service paid under the MPFS is the product of three factors:

•The Relative Value Unit (RVU), which reflects the resources involved in completing the service

•The geographic adjustment factor, which recognizes that costs incurred vary depending on the location where you practice and

•The nationally uniform conversion factor, which converts RVUs into payment amounts

• <u>Note</u>: Optional – Hold up a copy of a Medicare Physician Fee Schedule for the learners to see.

05 3 Hour Medicare Program Training Module

Chapter 2

Slide

Nonparticipating Provider/Supplier

- Accept assignment on claim-by-claim basis
- Charge beneficiary up to limiting charge

38

Notes

Instruction

•The nonparticipating provider or supplier may choose to accept assignment of Medicare claims on a claim-by-claim basis and may charge the beneficiary up to limiting charge or the maximum amount that can be charged for the services furnished (unless prohibited by State law).

•The limiting charge is 115 percent of the MPFS amount and applies to the following regardless of who furnishes them or bills for them:

- **•Physicians' services**
- **•Services and supplies commonly furnished in physicians' offices that are incident to physicians' services**
- **•Outpatient physical and occupational therapy services furnished by an independently practicing therapist**
- **•Diagnostic tests and**
- **•Radiation therapy services**

Slide

Limiting Charge

MPFS Allowed Amount for Procedure "X"	$200.00
Nonparticipating Provider/Supplier Allowed Amount for Procedure "X"	$190.00
Limiting Charge for Procedure "X"	$218.50
Beneficiary Coinsurance and Limiting Charge Portion Due to Provider/Supplier	$ 66.50

39

Notes

Instruction

•This chart shows an example of a limiting charge.

•The MPFS allowed amount for procedure "X" is $200.00.

•The nonparticipating provider or supplier allowed amount for procedure "X" is 5 percent lower than the MPFS allowed amount. So you would multiply $200.00 by .95, which equals $190.00.

•The limiting charge for procedure "X" is 115 percent of the MPFS allowed amount. So you would multiply $190.00 by 1.15, which equals $218.50.

•The beneficiary coinsurance is 20 percent of $190.00 (the nonparticipating provider or supplier allowed amount), which equals $38.00. And to get the limiting charge portion that is due to the provider or supplier, you would subtract $190.00 from $218.50, which equals $28.50. The total amount the beneficiary pays the provider or supplier is $38.00 plus $28.50, which equals $66.50.

05 3 Hour Medicare Program Training Module

Chapter 2

Slide

Participating/Nonparticipating Provider/Supplier Payment Amounts

	Participating Provider/Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/Supplier Who Does Not Accept Assignment
Submitted Amount	$125.00	$125.00	$109.25
Medicare Physician Fee Schedule Allowed Amount	$100.00	$ 95.00	$ 95.00
80 Percent of Medicare Physician Fee Schedule Allowed Amount	$ 80.00	$ 76.00	$ 76.00
Beneficiary Coinsurance Due to Provider	$ 20.00	$ 19.00	$ 33.25
Total Payment to Provider/Supplier	$100.00	$ 95.00	$109.25 ($95.00 x 1.15, limiting charge)

40

Notes

Instruction

•This chart depicts the payment amounts that participating and nonparticipating providers and suppliers receive.

•Note that the coinsurance amount due to the provider or supplier is paid after the deductible has been met. And payment for nonassigned claims goes to the beneficiary, who is responsible for paying the provider or supplier.

Slide

Protecting Your Practice

- Review claim reports
- Hire competent and ethical employees
- Do not routinely waive collection of deductibles, coinsurance, copayments

Notes

Instruction

•Here are some suggestions that can help you protect your practice. If you engage billing services or consultants to submit your claims, you should review reports regarding claims billed to ensure that they are consistent with your records. Complete administrative records should be kept for seven years.

•When you hire new employees, you should select competent and ethical employees, develop internal controls in order to minimize risk, implement procedural checks and balances to ensure appropriate interactions with Medicare, and conduct periodic quality checks of sensitive processes.

•If you provide free or discounted services (or a portion or free or discounted services), the services cannot be billed to Medicare or any secondary policy. It is unlawful to routinely waive the collection of deductibles, coinsurance, and copayments. If the patient is legitimately unable to pay for the services and this information is documented in the patient's records, the waiver of deductibles, coinsurance, and copayments is not considered unlawful.

05 3 Hour Medicare Program Training Module

Chapter 2

Slide

Protecting Your Practice

- Implement referral process
- Consider contractual agreements
- Implement compliance program

Notes

Instruction

•When a beneficiary requires a referral for specialized medical care or certain diagnostic tests or supplies, you should implement a process to ensure that only the services or tests ordered were furnished; specify the reason the services are being ordered whenever possible; personally complete all medical information on referrals; specify the quantity of medical supplies needed where applicable; be suspicious of entities that offer discounts, free services, or cash; and never certify the need for medical supplies for patients who have not been seen and examined.

•When you contract with individuals and other entities, consider the types of agreements and paperwork that must be executed, ethical standards of conduct, State and Federal regulations; and confidentiality obligations.

•Consider implementing a compliance program, which can assist in establishing an environment that promotes prevention, detection, and resolution of conduct that does not conform to legal, ethical, or program requirements.

05 3 Hour Medicare Program Training Module

Chapter 2

Slide

Cultural Competency

- Address patient's social and cultural background
- Assists in delivering high quality, effective health care
- Web-based training course

Notes

Instruction

•Our country is becoming increasingly diverse. Racial and ethnic minorities make up 30 percent of the American population and are expected to increase to 40 percent by 2030. Addressing a patient's social and cultural background will assist providers and suppliers in delivering high quality, effective health care and increase patient satisfaction, improve patient compliance, and reduce racial and ethnic health disparities.

•You may be interested in a free interactive web-based training cultural competency course titled *A Family Physician's Practical Guide to Culturally Competent Care*. Physicians can earn up to nine Category 1 Continuing Medical Education (CME) credits from the American Medical Association or nine CME credits from the American Academy of Family Physicians upon completion of the course.

Slide

Let's Review

- What are the identifying numbers providers and suppliers are assigned upon acceptance into the Medicare Program?
- What are the benefits of becoming a Medicare participating provider or supplier?

Notes

Instruction

•**Let's review the material we covered in this chapter.**

?

•**What are the identifying numbers providers and suppliers are assigned upon acceptance into the Medicare Program?**

- **Answer –**
  - National Provider Identifier
  - Provider Identification Number
  - Unique Physician/Practitioner Identification Number

?

•**What are the benefits of becoming a Medicare participating provider or supplier?**

- **Answer –**
  - •Receive five percent higher Medicare Physician Fee Schedule allowances
  - •Limiting charge provisions are not applicable
  - •Included in the Medicare Participating Physician and Supplier Directory

Slide

CHAPTER 3

MEDICARE REIMBURSEMENT

Notes

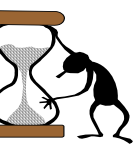
Instruction

- **Chapter Three explains the Medicare reimbursement process.**

- **The learning objectives for Chapter Three are:**

  - Describe how Medicare providers and suppliers are reimbursed for the items and services they furnish
  - Identify when Medicare is the secondary payer
  - Recognize physician incentive and bonus payments

- **Materials required:**
  - **None**



- **Time required to complete this training module:**
  - **Approximately 15 minutes**

05 3 Hour Medicare Program Training Module

Chapter 3

Slide

Medicare Claims

- Must submit claims for services
- Cannot charge patient for completing or filing claim
- File on or before December 31 of year following year services furnished

46

Notes

Instruction

•A claim is a filing from a provider, supplier, or beneficiary that includes a request for Medicare payment and furnishes the Contractor with sufficient information to determine whether payment of benefits is due and the amount of payment.

•When you furnish covered services to Medicare patients, you are required to submit a claim for your services and cannot charge beneficiaries for completing or filing a claim.

•In general, fee-for-service claims must be filed timely. This means that claims must be filed on or before December 31 of the calendar year following the year in which services were furnished.

Slide

Exceptions to Mandatory Filing

- Certain secondary payer claims
- Services furnished outside the U.S.
- Services initially paid by third-party insurer
- Unusual or excluded services
- Provider/supplier opted out, excluded, or debarred

47

Notes

Instruction

•Providers and suppliers are not required to file claims on behalf of Medicare beneficiaries when the claim:

•Is for services for which Medicare is the secondary payer, the primary insurer's payment is made directly to the beneficiary, and the beneficiary has not furnished the information needed to submit the Medicare secondary claim

•Is for services furnished outside the U.S

•Is for services initially paid by third-party insurers who then file Medicare claims to recoup what Medicare pays as the primary insurer

•Is for other unusual services

•Is for excluded services (some supplemental insurers who pay for these services may require a Medicare claims denial notice before making payment)

•Providers and suppliers also are not required to file claims when they have opted out of the Medicare Program by signing a private contract with the beneficiary or they have been excluded or debarred from the Medicare Program.

05 3 Hour Medicare Program Training Module

Chapter 3

Slide

Electronic Claims

- Most must submit claims electronically
- Advantages
  - Paid 14 days after receipt
  - No mailroom processing
  - Claim filing errors notification

48

Notes

Instruction

•Most providers and suppliers must submit claims electronically via Electronic Data Interchange (EDI) in the Health Insurance Portability Act format. After you complete a Centers for Medicare & Medicaid Services Standard EDI Enrollment Form and send it to the Contractor, you will receive a sender number which is required in order to submit electronic claims.

•The advantages of submitting electronic claims include:

•They can be paid 14 days after receipt, compared to 29 days after receipt for payment of paper claims (effective January 1, 2006, the waiting period for payment of paper claims was extended)

•Mailroom processing is eliminated and

•Payment Contractor systems may notify you about critical claim filing errors so that claims can be corrected before they enter the Medicare claims processing system

05 3 Hour Medicare Program Training Module

Chapter 3

Slide

Deductibles, Coinsurance, and Copayments

- Must collect from beneficiary

49

Notes

Instruction

•Providers and suppliers must collect unmet deductibles, coinsurance, and copayments from the beneficiary.

•The deductible is the amount the beneficiary pays for health care before Medicare begins to pay, either for each benefit period for Part A or each year for Part B. These amounts can change every year.

•Coinsurance is the percent of the Medicare-approved amount that the beneficiary pays after he or she pays the plan deductible.

•In some Medicare plans, fixed amounts called copayments are paid by the beneficiary for each medical service.

•On assigned claims, the beneficiary is responsible for:

- **•Unmet deductibles, applicable coinsurance and copayments, and charges for services and supplies that are not covered.**

Slide

Medicare Secondary Payer

- Must ask beneficiaries about other insurance for
  - Every admission
  - Outpatient encounter
  - Start of care

50

Notes

Instruction

•Medicare law requires that providers and suppliers determine whether Medicare is the primary or secondary payer prior to submitting a claim. Providers and suppliers must ask beneficiaries or their representatives about other insurance for every admission, outpatient encounter, or start of care. Medicare is the secondary payer when the beneficiary is covered by:

•A Group Health Plan (GHP) and is age 65 or older

•An employer retirement plan and is age 65 or older or is disabled and is age 65 or younger

•A Large Group Health Plan and is disabled

•A GHP or Consolidated Omnibus Budget Reconciliation Act (COBRA) and has End-Stage Renal Disease

•A Workers Compensation Plan due to a job-related illness or injury

•The Federal Black Lung Program and has black lung disease

•Liability or no-fault insurance and has been in an accident

•Medicare and COBRA and is disabled or is age 65 or older or

•The Veterans Health Administration, when it has authorized non-Federal providers and suppliers to furnish items or services

Slide

Incentive/Bonus Payments

- Health Professional Shortage Area Incentive Payment
- Physician Scarcity Area Bonus Payment

51

Notes

Instruction

•A ten percent Health Professional Shortage Area (HPSA) incentive payment will be paid to physicians who furnish medical care in geographic areas that have been designated as primary medical care HPSAs by the Health Resources and Services Administration.

•As of January 1, 2005, Medicare pays primary care physicians who furnish services in a primary care scarcity county and specialty physicians who furnish services in a specialist care scarcity county a Physician Scarcity Area (PSA) bonus payment, which is equal to five percent of the amount paid for their professional services under the Medicare Physician Fee Schedule.

•Physicians may be entitled to a ten percent HPSA incentive payment and/or a five percent PSA bonus payment for the same service as long as the area where the service is performed meets both sets of criteria.

•The HPSA and PSA payments are based on the paid amount of the claim and are paid on quarterly basis.

Slide

Medicare Notices

- Advance Beneficiary Notice
- Certificate of Medical Necessity
- Notice of Exclusion from Medicare Benefits
- Remittance Advice
- Medicare Summary Notice

52

Notes

Instruction

•These are notices that you may use or receive from Medicare:

•Advance Beneficiary Notice, which is a written notice that a provider or supplier gives to a beneficiary before items or services are furnished to advise him or that specified items or services may not be covered by Medicare

•Certificate of Medical Necessity, which is included with claims for certain items that require additional information (for example, durable medical equipment)

•Notice of Exclusion from Medicare Benefits, which is used to advise the beneficiary in advance that Medicare will not pay for certain items and services and

•Remittance Advice, which is a notice of payments and adjustments that is sent to providers, suppliers, and billers

•The Medicare Summary Notice is a notice that beneficiaries receive that lists all services or supplies that were billed to Medicare.

Slide

Other Health Insurance Plans

- Medicare Advantage
- Medicaid
- Medigap

53

Notes

Instruction

•Beneficiaries may be enrolled in these other health insurance plans:

•Medicare Advantage (MA). If you furnish services to a beneficiary enrolled in a MA Plan and do not have a contract with the MA Plan to furnish the services, you should bill the MA Plan. Prior to furnishing services to a MA Plan beneficiary, you should notify the beneficiary that he or she may be responsible for all charges for the health care services furnished.

•Medicaid is a cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources. Medicare covered services are paid first by the Medicare Program since Medicaid is always the payer of last resort.

•Medigap is a health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage.

Slide

Let's Review

- What are the advantages of filing Medicare claims electronically?
- What is a Health Professional Shortage Area incentive payment?

54

Notes

Instruction

• **Let's review the material we covered in this chapter.**

•**What are the advantages of filing Medicare claims electronically?**

• **Answer -**

• Can be paid 14 days after receipt, compared to 29 days for payment of paper claims

• Mailroom processing is eliminated.

• Payment Contractor systems may notify you about critical claim filing errors.

?

•**What is a Health Professional Shortage Area incentive payment?**

• **Answer -**

•A ten percent incentive payment that is paid to physicians who furnish medical care in geographic areas that have been designated as primary medical care Health Professional Shortage Areas by the Health Resources and Services Administration.

05 3 Hour Medicare Program Training Module

Chapter 3

Slide

CHAPTER 4

MEDIARE PAYMENT POLICIES

Notes

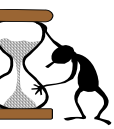
Instruction

- **Chapter Four explains Medicare payment policies.**

- **The learning objectives for Chapter Four are:**

  - Determine the services Medicare pays for
  - Determine the services that Medicare does not pay for

- **Materials required:**
  - **None**



- **Time required to complete this training module:**
  - **Approximately 20 minutes**

Slide

Medically Necessary Services

- Proper, needed for diagnosis, treatment
- Furnished for diagnosis, direct care, treatment of medical condition
- Meet standards of good medical practice
- Not mainly for convenience

56

Notes

Instruction

•In general, Medicare pays for services that are considered medically reasonable and necessary to the overall diagnosis and treatment of the patient's condition. Services or supplies are considered medically necessary if they:

•Are proper and needed for diagnosis or treatment of the patient's medical condition

•Are furnished for the diagnosis, direct care, and treatment of the patient's medical condition

•Meet standards of good medical practice and

•Are not mainly for convenience of the patient, provider, or supplier

•Medicare pays for provider professional services that are furnished in the U.S. and in the home, office, institution, or at the scene of an accident.

05 3 Hour Medicare Program Training Module

Chapter 4

Slide

Covered Part A
Inpatient Hospital Services

- Bed and board
- Nursing and related services
- Use of hospital or Critical Access Hospital facilities
- Medical social services

57

Notes

Instruction

•Subject to certain conditions, limitations, and exceptions the following inpatient hospital or inpatient Critical Access Hospital (CAH) services are furnished to an inpatient of a participating hospital or participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

•Bed and board

•Nursing and other related services

•Use of hospital or CAH facilities

•Medical social services

Slide

Covered Part A
Inpatient Hospital Services

- Drugs, biologicals, supplies, equipment
- Other diagnostic/therapeutic services
- Medical or surgical services furnished by certain interns or residents
- Transportation services

58

Notes

Instruction

•These are additional services furnished to an inpatient of a qualified hospital:

•Drugs, biologicals, supplies, appliances, and equipment

•Certain other diagnostic or therapeutic services

•Medical or surgical services furnished by certain interns or residents in training and

•Transportation services including transport by ambulance

05 3 Hour Medicare Program Training Module

Chapter 4

Slide

Covered Part B Physician Services

- Surgery, consultations, office visits, institutional calls
- Services, supplies, outpatient hospital services incident to physicians' services
- Outpatient physical, occupational, speech-language pathology services

59

Notes

Instruction

•Covered Part B physician services include, but are not limited to:

•Surgery, consultations, office visits, and institutional calls

•Services and supplies furnished incident to physicians' professional services

•Outpatient hospital services furnished incident to physician services and

•Outpatient physical, occupational, and speech-language pathology services

05 3 Hour Medicare Program Training Module

Chapter 4

Slide

Incident to Physician Services

- In office or clinic
- By physician or auxiliary personnel under direct personal supervision
- Without charge or included in bill
- Integral, although incidental, part of service

Notes

Instruction

•To be covered incident to the services of a physician, services and supplies must meet the following requirements:

•Commonly furnished in physicians' offices or clinics

•Furnished by the physician or auxiliary personnel under the direct personal supervision of a physician

•Commonly furnished without charge or included in the physician's bill and

•An integral, although incidental, part of the physician's professional service

Slide

Commonly Furnished Services

- Hospice
  - Eligible for Part A
  - Terminal illness with prognosis of 6 months or less
  - Approved hospice program
  - Elects hospice

61

Notes

Instruction

•Hospice care is covered under Part A for the terminally ill beneficiary who meets all of the following conditions:

•He or she is eligible for Part A.

•He or she is certified as having a terminal disease with a prognosis of six months or less if the illness runs its normal course.

•He or she receives care from a Medicare-approved hospice program.

•And he or she signs a statement indicating that the hospice benefit has been elected and all rights to Medicare payments for services for the terminal illness and related conditions have been waived. Medicare will continue to pay for covered benefits that are not related to his or her terminal illness.

Slide

Commonly Furnished Services

- Expanded preventive services benefits

62

Notes

Instruction

•Preventive screenings and services, early detection of disease, and disease management along with professional advice on diet, exercise, weight control, and smoking cessation can help beneficiaries lead healthier lives and prevent, delay, or lessen the impact of disease.

•The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 expanded Part B coverage of preventive services to include an initial preventive physical examination (IPPE), cardiovascular screening blood tests, and diabetes screening tests.

Slide

Commonly Furnished Services

- Expanded preventive service benefits
  - Initial preventive physical examination

63

Notes

Instruction

•All beneficiaries enrolled in Part B with effective dates that begin on or after January 1, 2005 are eligible for the IPPE benefit, which is also known as the "Welcome to Medicare Physical." This one-time benefit must be received by the beneficiary within the first six months of Part B coverage.

Slide

Commonly Furnished Services

- Expanded preventive service benefits
  - Cardiovascular screening blood tests

64

Notes

Instruction

•For services furnished on or after January 1, 2005, these cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke are covered for all asymptomatic beneficiaries once every five years:

•Total cholesterol

•High-density lipoproteins and

•Triglycerides

Slide

Commonly Furnished Services

- Expanded preventive service benefits

  - Diabetes screening tests

65

Notes

Instruction

•For services furnished on or after January 1, 2005, Medicare covers diabetes screening tests with a referral from a physician or qualified nonphysician practitioner as follows:

•Beneficiaries who are non-diabetic and not previously diagnosed as pre-diabetic may receive one diabetes screening test within a 12-month period.

•Beneficiaries who have any of the following may receive a maximum of two diabetes screening tests within a 12-month period (but not less than 6 months apart):

- Have been diagnosed with pre-diabetes

- Have hypertension, dyslipidemia, obesity, previous identification of an elevated impaired fasting glucose or glucose tolerance or

- Have a risk factor for diabetes consisting of at least two of the following characteristics:

- **Overweight**
- **A family history of diabetes**
- **Age 65 or older**
- **A history of gestational diabetes mellitus or**
- **Delivery of a baby weighing greater than 9 pounds**

Slide

Commonly Furnished Services

- Influenza vaccinations
- Pneumococcal polysaccharide vaccinations

66

Notes

Instruction

•**Other preventive services covered under Part B include:**

•**One influenza vaccine and its administration per influenza season for all Medicare beneficiaries regardless of risk for the disease.**

•**Pneumococcal polysaccharide vaccine and its administration once in a lifetime for all Medicare beneficiaries.**

Slide

Commonly Furnished Services

- Smoking and tobacco cessation counseling

67

Notes

Instruction

•For services furnished on or after March 22, 2005, Medicare Part B covers two new levels of counseling -- intermediate and intensive -- for smoking and tobacco use cessation counseling. This coverage is beyond the minimal smoking and tobacco use cessation counseling that is already considered to be covered at each evaluation and management visit. Coverage is limited to beneficiaries who:

- **Are competent and alert at the time services are provided and**
- **•Use tobacco AND**
  - **•Have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or**
  - **•Are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use based on Food and Drug Administration-approved information.**

•Two cessation attempts are covered each year. Each attempt may include a maximum of 4 intermediate or intensive sessions, up to 8 sessions in a 12-month period.

05 3 Hour Medicare Program Training Module
Chapter 4

Slide

Commonly Furnished Services

- Telehealth services

68

Notes

Instruction

•Medicare beneficiaries are eligible for telehealth services that are presented from an originating site (location of the beneficiary) that is located in a rural Health Professional Shortage Area (HPSA) or non-Metropolitan Statistical Area county. Originating sites include the following:

- **•Physician or practitioner offices**
- **•Hospitals**
- **•Critical Access Hospitals**
- **•Rural Health Clinics and**
- **•Federally Qualified Health Centers**

Slide

Medicare
Does NOT Pay For

- Excluded services
- Not medically necessary services
- Services denied as bundled or included in basic allowance of another service
- Claims denied as “unprocessable”

Notes

Instruction

- **Medicare does not pay for:**
  - **Excluded services**
  - **Services that are considered not medically necessary**
  - **Services that have been denied as bundled or included in basic allowance of another service and**
  - **Claims that have been denied as “unprocessable”**

Slide

Let's Review

- What are medically necessary services?
- What are the 3 preventive services that were expanded under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003?

70

Notes

Instruction

•**Let's review the material we covered in this chapter.**

?

•**What are medically necessary services?**

- **Answer –**
  - •Services that are proper and needed for diagnosis or treatment of the patient's medical condition
  - •Services that are furnished for the diagnosis, direct care, and treatment of the patient's medical condition
  - •Services that meet standards of good medical practice
  - •Services that are not mainly for convenience of the patient, provider, or supplier

?

•**What are the three preventive services that were expanded under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003?**

- **Answer –**
  - •Initial preventive physical examination ("Welcome to Medicare Physical")
  - •Cardiovascular screening blood tests
  - •Diabetes screening tests

Slide

EVALUATION AND MANAGEMENT DOCUMENTATION

Notes

Instruction

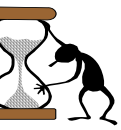
•**Chapter Five summarizes evaluation and management documentation.**

•**The learning objectives for Chapter Five are:**

- •Describe documentation guidelines for residents and teaching physicians
- •Identify the seven components that define the levels of evaluation and management

Materials required:

- • ***Medicare Physician Guide***



- **Time required to complete this training module:**
  - **Approximately 45 minutes**

05 3 Hour Medicare Program Training Module

Chapter 5

Slide

Guidelines for Residents and Teaching Physicians

- Attending – personally documents participation, either performed or present during critical/key portions
- Residents, teaching physicians, students may document services

72

Notes

Instruction

•Both residents and teaching physicians may document physician services in the patient's medical record. The documentation must be dated and contain a legible signature or identity and may be dictated and transcribed, typed, hand-written, or computer-generated.

•The attending physician who bills Medicare for evaluation and management (E/M) services in the teaching setting must, at a minimum, personally document his or her participation in the management of the patient and that he or she performed the service or was physically present during the critical or key portion(s) of the service performed by the resident (the resident's certification that the attending physician was present is not sufficient).

•Students may also document services in the patient's medical record. The teaching physician may refer only to a student's E/M documentation that is related to a review of systems (ROS) and/or past, family, and/or social history (PFSH). If the student documents E/M services, the teaching physician must verify and repeat documentation of the physical examination and medical decision making activities of the service.

Slide

Guidelines for Residents and Teaching Physicians

- Initial hospital care
- Emergency department visits
- Office visits – new patients
- Office and hospital consultations

73

Notes

Instruction

•For initial hospital care, emergency department visits, office visits for new patients, and office and hospital consultations, the teaching physician must enter a personal notation that demonstrates the appropriate level of service that the patient requires and documents his or her participation in the three key components. The three key components are history, examination, and medical decision making.

•If the teaching physician repeats key elements of the service components that the resident previously obtained and documented, his or her note may be brief, summarize comments that relate to the resident's entry, and confirm or revise these key elements:

- **•Relevant history of present illness (HPI) and prior diagnostic tests**
- **•Major finding(s) of the physical examination**
- **•Assessment, clinical impression, or diagnosis and**
- **•Plan of care**

Slide

Guidelines for Residents and Teaching Physicians

- Subsequent hospital care and office visits – established patients

74

Notes

Instruction

•For subsequent hospital care and office visits for established patients, the teaching physician must enter a personal notation that highlights two of the three key components of these services. These components are history, physical examination, and medical decision making.

•For follow-up visits for established patients, the guidelines for initial hospital care, emergency department visits, office visits for new patients, and office and hospital consultations guidelines must also be followed.

Slide

Guidelines for Residents and Teaching Physicians

- Primary care exception

75

Notes

Instruction

•Medicare may grant a primary care exception within an approved Graduate Medical Education Program in which the teaching physician is paid for certain E/M services the resident performs when the teaching physician is not present. The primary care exception applies to the following lower and mid-level E/M services:

•New Patient - CPT® Codes 99201, 99202, and 99203 and

•Established Patient - CPT Codes 99211, 99212, and 99213

•Effective January 1, 2005, the primary care exception also applies to the initial preventive physical examination, also known as the "Welcome to Medicare Physical" - Healthcare Common Procedure Coding System code G3044, the initial preventive physical examination, face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment.

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Slide

Background
Evaluation and Management

- Translates patient care work into claims and reimbursement
- Ensures correct payments
- Supports correct E/M code level
- Provides validation for medical review

76

Notes

Instruction

•Medicare pays physicians based on diagnostic and procedure codes that are derived from medical documentation. E/M documentation is the pathway that translates a physician's patient care work into the claims and reimbursement mechanism. This pathway's accuracy is critical in ensuring that physicians are paid correctly for their work, supporting the correct E/M code level, and providing the validation required for medical review.

Slide

Medical Record Documentation

- Records facts, findings, observations
- Facilitates treatment, communication, claims and utilization review, data collection

77

Notes

Instruction

•Medical record documentation is required in order to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes.

•The medical record facilitates:

•The ability to evaluate and plan the patient's immediate treatment and to monitor his or her health over time

•Communication and continuity of care among physicians and other health care professionals

•Accurate and timely claims review and payment

•Appropriate utilization review and quality of care evaluations and

•Collection of data that may be useful for research and evaluation

Slide

Seven General
Principles of Documentation

1. Medical record should be complete and legible

78

Notes

Instruction

•The seven general principles of documentation are applicable to all types of medical and surgical services in all settings. For E/M services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient's status.

•The first principle is: the medical record should be complete and legible.

Slide

Seven General Principles of Documentation

2. Each encounter includes
   - Reason for encounter, relevant history, physical examination findings, prior test results
   - Assessment, clinical impression, diagnosis
   - Plan for care
   - Date, legible identity of observer

79

Notes

Instruction

•The second principle is: documentation of each patient encounter should include –

- **•Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results**
- **•Assessment, clinical impression, or diagnosis**
- **•Plan for care and**
- **•Date and legible identity of the observer**

Slide

Seven General
Principles of Documentation

3. Rationale for ordering diagnostic tests
4. Diagnoses accessible to treating/ consulting physician
5. Identify health risk factors

80

Notes

Instruction

•The third principle is: if not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

• The fourth principle is: past and present diagnoses should be accessible to the treating and/or consulting physician.

•The fifth principle is: appropriate health risk factors should be identified.

Slide

Seven General Principles of Documentation

6. Document progress, response to and changes in treatment, revision of diagnosis
7. Current Procedural Terminology and International Classification of Diseases codes supported

81

Notes

Instruction

•The sixth principle is: the patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

•And the seventh principle is: Current Procedural Terminology and International Classification of Diseases, 9th Revision, Clinical Modification codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record. For example, a patient presents with signs and systems that suggest a cold. When the claim is submitted, it has a procedure code that correlates to a foot x-ray and a diagnosis code of cold. This would be considered conflicting information.

Slide

Seven Components Evaluation and Management

- History
- Examination
- Medical decision making
- Counseling
- Coordination of Care
- Nature of presenting problem
- Time

82

Notes

Instruction

- **The seven components that define the levels of E/M services are:**
  - **History**
  - **Examination**
  - **Medical decision making**
  - **Counseling**
  - **Coordination of care**
  - **Nature of presenting problem and**
  - **Time**

Slide

Three Key Components

Procedure Code	History	Examination	Medical Decision Making
99201	Problem Focused History	Problem Focused Examination	Straightforward
99202	Expanded Problem Focused History	Expanded Problem Focused Examination	Straightforward
99203	Detailed History	Detailed Examination	Low Complexity
99204	Comprehensive History	Comprehensive Examination	Moderate Complexity
99205	Comprehensive History	Comprehensive Examination	High Complexity

83

Notes

Instruction

•This is the "New Patient Visit" Table that we will use to determine the appropriate level of service provided to a new patient. Procedure codes that determine the level of service and amount of reimbursement are listed in the left column labeled "Procedure Code."

•The top row of the chart has the three key components in selecting the levels of E/M services which are "History," "Examination," and "Medical Decision Making."

•The possible levels of the three key components are shown in the next rows. To select the appropriate procedure code, each of the three key components must meet or exceed the requirements for that procedure code. In other words, all three key components must meet on the same row in the table as the procedure code being selected.

•An exception to the three key component rule are visits that consist predominantly of counseling or coordination of care such as when 50 percent or more of your time must be spent face-to-face with the patient counseling and/or coordinating care, for which time is the key or controlling factor to qualify for a particular level of E/M service.

Slide

History

- 4 levels
- Includes elements
  - Chief complaint
  - History of present illness
  - Review of systems
  - Past, family, and/or social history

84

Notes

Instruction

•Please refer to pages 114 through 119 of the *Medicare Physician Guide*.

•The levels of E/M services are based on four levels of history:

- **•Problem Focused**
- **•Expanded Problem Focused**
- **•Detailed and**
- **•Comprehensive**

•Each type of history includes some or all of the following elements:

- **•Chief complaint (CC)**
- **•HPI**
- **•ROS and**
- **•PFSH**

Slide

History

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Level of History
Brief (1-3 elements)	N/A	N/A	Problem Focused
Brief (1-3 elements)	Problem Pertinent (system directly related to problem identified in HPI)	N/A	Expanded Problem Focused
Extended (4 or more elements)	Extended (system directly related to problem identified in HPI and a limited number (2-9) of additional systems)	Pertinent (at least one specific item from any of the three history areas must be documented)	Detailed
Extended (4 or more elements)	Complete (system directly related to problem identified in HPI plus 10 additional systems must be reviewed)	Complete (three * specific items from any of the three PFSH areas must be documented.) (* Two if established patient)	Comprehensive
Elements: location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms	ROS - Constitutional, eyes, ears, nose, throat, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeltal, integumentary, neurological, psychiatric, endocrine, hematological, lymphatic, allergic, immunological	PFSH areas Past history Family history Social history	

85

Notes

Instruction

•In this table, the first column is the HPI. Let's say your patient had an "Extended" HPI. This means that you must document at least four or more elements in the patient's medical record.

•The second column contains the ROS. This is a series of questions that a physician will ask a patient to identify signs and/or symptoms the patient is experiencing or has experienced. Let's say you have an "Extended" ROS. This means the medical record must reflect that the patient was asked questions about the system directly related to the CC and two to nine additional systems.

•In the third column is the PFSH. Let's say you have selected a "Pertinent" PFSH. This means the medical record must reflect that at least one specific item was documented from any of the three "Past, Family, and Social History" areas.

•Because the levels of HPI, ROS, and PFSH meet on the same row, the appropriate level of history is "Detailed."

Slide

History

Procedure Code	History	Examination	Medical Decision Making
99201	Problem Focused History	Problem Focused Examination	Straightforward
99202	Expanded Problem Focused History	Expanded Problem Focused Examination	Straightforward
99203	Detailed History	Detailed Examination	Low Complexity
99204	Comprehensive History	Comprehensive Examination	Moderate Complexity
99205	Comprehensive History	Comprehensive Examination	High Complexity

86

Notes

Instruction

- **A "Detailed" level of history was selected for the new patient in the previous slide, which means that these were documented in the patient's medical record:**
  - **CC**
  - **"Extended" HPI**
  - **"Extended" ROS and**
  - **"Pertinent" PFSH**
- **The first component of the new patient visit, history, has been completed.**

Slide

Examination

- 4 types of examinations
- General multi-system or single organ system

87

Notes

Instruction

•Please refer to pages 119 through 120 of the *Medicare Physician Guide*.

•The levels of E/M services are based on four types of examinations:

• Problem Focused, which is a limited examination of the affected body area or organ system

• Expanded Problem Focused, which is a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)

• Detailed, which is an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s) and

• Comprehensive, which is a general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)

• Physicians can choose to perform either a general multi-system or single organ system examination.

•General multi-system and single organ system examinations can be performed by any physician, regardless of specialty.

Slide

General Multi-System Examination

Level of Examination	Perform and Document
Problem Focused	1-5 elements identified by a bullet.
Expanded Problem Focused	At least six elements identified by a bullet.
Detailed	At least two elements identified by a bullet from each of six organ systems or body areas or at least 12 elements identified by a bullet in two or more organ systems or body areas.
Comprehensive	Perform all elements identified by a bullet in at least nine body areas or organ systems and document at least two elements identified by a bullet from each of the nine systems or areas.

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Notes

Instruction

•Please refer to pages 120 through 121 of the *Medicare Physician Guide*.

•This slide depicts the content and documentation requirements for each level of examination for the general multi-system examination, which includes several organ systems or body areas.

- **•A Problem Focused Examination should include one to five elements identified by a bullet in one or more organ systems**
- **•An Expanded Problem Focused Examination should include at least six elements identified by a bullet in one or more organ system(s) or body area(s)**
- **•A Detailed Examination should include at least two elements identified by a bullet from each of of six body areas or organ systems or at least twelve elements in two or more body areas or organ systems and**
- **•A Comprehensive Examination should include all the elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of the nine areas or systems**

• The specific requirements for each system or body area must be met in order to receive credit for performing that part of the examination.

Slide

General Multi-System Examination

- Elements of examination

89

Notes

Instruction

•Please refer to the "General Multi-System Examination" Tables on pages 122 through 126 of the *Medicare Physician Guide*.

• "Organ Systems" and "Body Areas" are shown in the left columns of the tables.

• The "Elements of Examination" are shown in the right columns of the tables.

• In the first section, "Constitutional," note the requirement that any three of the seven vital signs must be measured and documented in order to receive credit for performing this element.

Slide

General Multi-System Examination

Level of Examination	Perform and Document
Problem Focused	1-5 bulleted elements in one or more organ system(s) or body area(s).
Expanded Problem Focused	At least six bulleted elements in one or more organ system(s) or body area(s).
Detailed	At least two bulleted elements from each of six organ systems or body areas or at least 12 bulleted items in two or more organ systems or body areas.
Comprehensive	Perform all bulleted elements in at least nine organ systems or body areas and document at least two elements identified by a bullet from each area or system.

90

Notes

Instruction

•This slide shows that a general multi-system examination was performed and the patient's level of examination was determined to be "Detailed." The selection of "Detailed" under the "Level of Examination" requires the documentation of at least two elements identified by a bullet from each of six body areas or organ systems or at least twelve elements identified by a bullet in two or more body areas or organ systems.

Slide

Single Organ System Examination

Level of Examination	Perform and Document
Problem Focused	1-5 bulleted elements in a **shaded** or **unshaded** box.
Expanded Problem Focused	At least six bulleted elements in a **shaded** or **unshaded** box.
Detailed	At least twelve bulleted elements in a **shaded** or **unshaded** box.
Comprehensive	Perform all bulleted elements in a **shaded** or **unshaded** box. Document all bulleted elements in the **shaded** box and at least one bulleted element in an **unshaded** box.

91

Notes

Instruction

•The "Single Organ System Examination" Tables can be found on pages 127 through 151 of the *Medicare Physician Guide*.

•There are separate and distinct examinations for several single organ systems.

•The same four levels of examination apply; however, the requirements are a little different because some areas of the "Single Organ System Examination" Tables are shaded. When selecting the level of examination, physicians must ensure that all requirements for the shaded and unshaded boxes have been met.

05 3 Hour Medicare Program Training Module

Chapter 5

Slide

New Patient Visit

Procedure Code	History	Examination	Medical Decision Making
99201	Problem Focused History	Problem Focused Examination	Straightforward
99202	Expanded Problem Focused History	Expanded Problem Focused Examination	Straightforward
99203	Detailed History	Detailed Examination	Low Complexity
99204	Comprehensive History	Comprehensive Examination	Moderate Complexity
99205	Comprehensive History	Comprehensive Examination	High Complexity

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Notes

Instruction

•Going back to the "New Patient Visit" Table, so far we've determined that a "Detailed" level of history was obtained from a new patient and a "Detailed" level of examination was performed during the office visit.

Slide

Medical Decision Making

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

93

Notes

Instruction

- **Please refer to page 152 of the *Medicare Physician Guide*.**
- **The levels of E/M services recognize four levels of medical decision making:**
  - **Straightforward**
  - **Low complexity**
  - **Moderate complexity and**
  - **High complexity**

Slide

Medical Decision Making

Number of Diagnoses/ Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications, Morbidity, and/or Mortality	Type of Medical Decision Making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

94

Notes

Instruction

• This is the "Medical Decision Making" Table. To qualify for a given type of decision making, two of the three elements in the table must be either met or exceeded.

• Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

•Number of possible diagnoses and/or management options that must be considered

•Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed and

•Risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), diagnostic procedure(s), and/or the possible management options

Slide

Medical Decision Making

Number of Diagnoses/ Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications, Morbidity, and/or Mortality	Type of Medical Decision Making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

95

Notes

Instruction

• On page 156 of the *Medicare Physician Guide*, you can see the "Table of Risk," which may be used to help determine whether the risk of significant complications, morbidity and/or mortality is minimal, low, moderate, or high.

• Since the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk.

•The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.

• The highest level of risk in any one category -- presenting problem(s), diagnostic procedure(s) ordered, or management options -- determines the overall risk.

Slide

Medical Decision Making

Number of Diagnoses/ Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Medical Decision Making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

96

Notes

Instruction

- **In this example these selections were made for each of the three elements of medical decision making:**
  - **"Extensive" for the "Number of Diagnoses and/or Management Options"**
  - **"Extensive" for the "Amount and/or Complexity of Data to be Reviewed" and**
  - **"Moderate" for the "Risk of Complications, Morbidity, and/or Mortality"**
- **A "High Complexity" level of decision making may be selected since two of the three elements were met at the "High Complexity" level.**

Slide

New Patient Visit

Procedure Code	History	Examination	Medical Decision Making
99201	Problem Focused History	Problem Focused Examination	Straightforward
99202	Expanded Problem Focused History	Expanded Problem Focused Examination	Straightforward
99203	Detailed History	Detailed Examination	Low Complexity
99204	Comprehensive History	Comprehensive Examination	Moderate Complexity
99205	Comprehensive History	Comprehensive Examination	High Complexity

97

Notes

Instruction

•Let's completely review the example of the new patient visit. A "Detailed" level of history, "Detailed" level of examination and "High Complexity" of medical decision making was performed and documented. Since all three key components meet on the same row as procedure code 99203 in the table, procedure code 99203 should be selected.

Slide

Established Patient Visit

Procedure Code	History	Examination	Medical Decision Making
99211	N/A	N/A	N/A
99212	Problem Focused History	Problem Focused Examination	Straightforward
99213	Expanded Problem Focused History	Expanded Problem Focused Examination	Low Complexity
99214	Detailed History	Detailed Examination	Moderate Complexity
99215	Comprehensive History	Comprehensive Examination	High Complexity

98

Notes

Instruction

•This table shows that for established patient visits, two of the three key components must meet on the same row as the procedure code selected. A "Detailed" level of history, "Detailed" level of examination," and a "High Complexity" of medical decision making was performed and documented. Two of the three, "Detailed History" and "Detailed Examination," meet on the same row as procedure code 92214. Therefore, procedure code 92214 should be selected.

Slide

Let's Review

- What 2 items must an attending physician personally document in the teaching setting?
- What are the 7 components that define the levels of evaluation and management services?

99

Notes

Instruction

• **Let's review the material we have covered in this chapter.**

?

•What two items must an attending physician personally document in the teaching setting?

• **Answer –**

•His or her participation in the management of the patient

•That he or she performed the service or was physically present during the critical or key portion(s) of the service performed by the resident

?

• What are the seven components that define the levels of evaluation and management services?

• **Answer –**

• History, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time

Slide

CHAPTER 6

PROTECTING THE MEDICARE TRUST FUND

Notes

Instruction

- **Chapter Six explains how the Medicare Trust Fund is protected.**

- **The learning objectives for Chapter Six are:**
  - Identify the goal of the Medicare Integrity Program
  - Describe the medical review process
  - Determine the two types of coverage determinations
  - Define fraud
  - Define abuse
  - Identify the potential legal actions that may be imposed if a provider, supplier, or health care organization has committed fraud and abuse

- **Materials required:**
  - **None**

- **Time required to complete this training module:**
  - **Approximately 20 minutes**

05 3 Hour Medicare Program Training Module

Chapter 6

Slide

Medicare Integrity Program

- Pay it right

101

Notes

Instruction

•The goal of the Medicare Integrity Program (MIP) is to pay it right – pay the right amount, to the right provider or supplier, for the right service, to the right beneficiary. Some of the MIP or payment safeguard activities that Contractors complete include data analysis, medical review (MR), anti-fraud, and Medicare Secondary Payer.

05 3 Hour Medicare Program Training Module

Chapter 6

Slide

Medical Review Process

- Review claims
- Target problem areas – Progressive Corrective Actions

102

Notes

Instruction

- **The MR process includes:**
  - **Reviewing claims appropriately submitted to Medicare Contractors when atypical billing patterns or particular kinds of problems are identified.**
  - **Ensuring that MR activities are targeted at identified problem areas and that the corrective actions imposed are appropriate for the severity of the problem through Progressive Corrective Actions.**

05 3 Hour Medicare Program Training Module
Chapter 6

Slide

Medical Review Process

- Validate claim errors
- Classify severity of problems, collect overpayments, steps to correct

103

Notes

Instruction

- **The MR process also includes:**
  - **Validating claim errors through the use of probe reviews, which can either examine 20 to 40 claims per provider for provider-specific problems or examine approximately 100 claims from multiple providers for widespread, larger problems such as a spike in billing for a specific procedure.**
  - **When a probe review verifies that an error exists, the severity of the problem is classified as minor, moderate, or significant which is determined by the provider-specific error rate, dollar amounts improperly paid, and past billing history. Overpayments are collected and a determination is made as to what steps need to be taken to correct the problem.**

05 3 Hour Medicare Program Training Module

Chapter 6

Slide

National Coverage Determinations

- Identifies extent to which Medicare covers specific services, procedures, and technologies on national basis

104

Notes

Instruction

•There are two types of coverage determinations that assist providers and suppliers in coding correctly and billing Medicare only for covered items and services.

•The first type is called a National Coverage Determination (NCD) which sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare Contractors are required to follow NCDs. Prior to an NCD taking effect, the Centers for Medicare & Medicaid Services (CMS) must first issue a Manual Transmittal, ruling, or *Federal Register* Notice. If a NCD and a Local Coverage Determination (LCD) exist concurrently regarding the same coverage policy, the NCD takes precedence.

Slide

Local Coverage Determinations

- In absence of NCD, within specified geographic area
- Coverage criteria, medical necessity, codes integral to discussion of medical necessity, references

105

Notes

Instruction

• LCDs, formerly called Local Medical Review Policies, are made in the absence of a specific NCD by local Medicare Contractors at their own discretion to provide guidance to the public and the medical community within a specified geographic area. LCDs outline coverage criteria, define medical necessity, provide codes that describe what is and is not covered when the codes are integral to the discussion of medical necessity, and provide references upon which a policy is based.

Slide

Fraud and Abuse

- Preventing fraud and abuse

106

Notes

Instruction

- **CMS emphasizes early detection and prevention of fraud and abuse. An estimated 10 percent of Medicare costs are wrongly spent on incidences of fraud and abuse. The efforts of many groups help deter health care fraud and abuse and protect beneficiaries from harm by identifying suspicious Medicare charges and activities, investigating and punishing those who commit Medicare fraud and abuse, and ensuring that money lost to fraud and abuse is returned to the Medicare Trust Fund.**

05 3 Hour Medicare Program Training Module
Chapter 6

Slide

Fraud

• Intentional use of false statements or fraudulent schemes to obtain payment for, or to cause another to obtain payment for, items or services payable under Federal health care program

107

Notes

Instruction

•Federal health care fraud generally involves a person or entity's intentional use of false statements or fraudulent schemes to obtain payment for, or to cause another to obtain payment for, items or services payable under a Federal health care program. Some examples of fraud are billing for services not furnished; soliciting, offering, or receiving a kickback, bribe, or rebate; and consistently using billing or revenue codes that describe more extensive services than those actually performed or "upcoding."

Slide

Abuse

- Intentional or unintentional
- Directly or indirectly results in unnecessary or increased costs to the Medicare Program

108

Notes

Instruction

•In general, program abuse, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicare Program. Many abusive practices are subsequently determined to be fraudulent. For example, if a provider or supplier ignores Medicare guidance, education efforts, warnings, or advice that abusive conduct is inappropriate and he or she continues to engage in the same or similar conduct, the conduct could be considered fraudulent.

Slide

Potential Legal Actions

- Investigations
- Civil Monetary Penalties

109

Notes

Instruction

•It is a Federal crime to commit fraud against the U.S. government, including the Medicare Program. A provider, supplier, or health care organization that has been convicted of fraud may receive a significant fine, prison sentence, or be temporarily or permanently excluded from Medicare and other Federal health care programs. In some states, providers, suppliers, and health care organizations may also lose their licenses. A Program Safeguard Contractor or Medicare Contractor Benefit Integrity unit investigates and documents potential fraud and abuse and, when appropriate, refers such matters to the Office of Inspector General (OIG).

•Many violations of Medicare laws and regulations are subject to the imposition of Civil Monetary Penalties (CMP). Depending on the violation, the CMP amount may be up to $10,000 per violation and exclusion from the Medicare Program may be imposed.

05 3 Hour Medicare Program Training Module

Chapter 6

Slide

Potential Legal Actions

- Deny or revoke Medicare PIN
- Suspend payment
- Exclude from participation

110

Notes

Instruction

• CMS has the authority to deny an individual or entity's application for a Medicare Provider Identification Number (PIN) or to revoke a Medicare PIN if there is evidence of impropriety (for example., previous convictions, falsifying information on the application, or State or Federal licensure or certification requirements are not met).

•CMS has the authority to suspend payment to individuals and entities when there is reliable information that an overpayment exists, fraud exists, willful misrepresentation exists, or payments to be made may not be correct.

•The OIG has the authority to exclude individuals and entities from participation in all Federal health care programs, including the Medicare Program. While the exclusion remains in effect, the individual or entity will not be able to claim payment for any items or services furnished, ordered, or prescribed in any capacity to program patients. In addition, excluded individuals are not eligible for Federally-insured loans, Federally-funded research grants, and other programs administered by Federal agencies.

Slide

Report Suspected Fraud or Abuse

- OIG National Hotline
  (800) 447-8477
- Medicare Customer Service Center
  (800) 633-4227

111

Notes

Instruction

•To report suspected fraud or abuse you may contact either:

•OIG National Hotline at (800) 447-8477 or

•Medicare Customer Service Center at (800) 633-4227

05 3 Hour Medicare Program Training Module

Chapter 6

Slide

Let's Review

- What are the 2 types of coverage determinations that assist providers and suppliers in coding correctly and billing Medicare only for covered items and services?
- What is abuse?

112

Notes

Instruction

• **Let's review the material we have covered in this chapter.**

?

•What are the two types of coverage determinations that assist providers and suppliers in coding correctly and billing Medicare only for covered items and services?

- **Answer –**
  - •National Coverage Determinations
  - •Local Coverage Determinations

?

•What is abuse?

- **Answer –**
  - •May be intentional or unintentional and directly or indirectly results in unnecessary or increased costs to the Medicare Program

Slide

CHAPTER 7

**INQUIRIES,
OVERPAYMENTS,
AND APPEALS**

Notes

Instruction

- **Chapter Seven discusses inquiries, overpayments and appeals.**

- **The learning objectives for Chapter Seven are:**

  - Describe how providers and suppliers can find answers to inquiries
  - Identify the reasons overpayments are often paid
  - Identify the five levels of the fee-for-service appeals process
  - Define a reopening

- **Materials required:**
  - **None**

- **Time required to complete this training module:**
  - **Approximately 10 minutes**

05 3 Hour Medicare Program Training Module
Chapter 7

Slide

Inquiries

- By telephone or in writing
- Interactive Voice Response Services

114

Notes

Instruction

•Medicare providers and suppliers may submit inquiries about claims, coverage, and reimbursement guidelines to Medicare Contractors either by telephone or in writing. Customer Service Representatives (CSR) are available to handle telephone inquiries continuously during normal business hours for all time zones of the geographic area serviced, Monday through Friday. Contractors also use automated self-help tools such as Interactive Voice Response (IVR) services, which may be available up to 24 hours a day. You can find information about the following topics via IVR:

•Normal business hours

•CSR service hours of operation

•General Medicare Program

•Appeals

•Claims in process and claims completed and

•Definitions frequently used on the Remittance Advice Remark Codes and/or Claim Adjustment Reason Codes

05 3 Hour Medicare Program Training Module
Chapter 7

Slide

Overpayments

- Duplicate submission
- Incorrect payee
- Excluded or medically unnecessary services
- Should have been secondary insurer

115

Notes

Instruction

• Overpayments are funds that a provider, supplier, or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations. Once a determination of overpayment has been made, the amount of overpayment becomes a debt owed to the Federal government. Federal law requires the Centers for Medicare & Medicaid Services to seek recovery of overpayments, regardless of how an overpayment is identified or caused. Overpayments are often paid due to:

•Duplicate submission of the same service or claim

•Payment to the incorrect payee

•Payment for excluded or medically unnecessary services or

•Payment made as the primary insurer when Medicare should have paid as the secondary insurer.

•If Medicare pays more than the correct amount in error, providers and suppliers should make voluntary refunds as soon as possible, without waiting for notification.

Slide

Five Levels of Fee-for-Service Appeals

- First level – Redetermination by Contractor
- Second level – Reconsideration by Qualified Independent Contractor

116

Notes

Instruction

•An appeal is an independent review of an initial determination made by a Medicare Contractor. Generally, a party to the initial determination is entitled to an appeal if he or she is dissatisfied with the determination and files a timely appeal request is that contains the necessary information needed to process the request.

•The first level of a fee-for-service appeal is the redetermination, which is an independent review of an initial determination by an employee of the Contractor who was not involved in making the initial determination. A request for a redetermination must be filed within 120 calendar days of the date the notice of initial claim determination. At this level of appeal, there is no amount in controversy (AIC) requirement.

•A party dissatisfied with the redetermination decision may request a second level of appeal, which is a reconsideration by a Qualified Independent Contractor (QIC). For all redeterminations issued on or after January 1, 2006, the reconsideration by the QIC replaces the Hearing Office Hearing previously conducted by Part B Contractors. Appeals of redeterminations issued prior to January 1, 2006 will be conducted by hearing officers. A party must file a written request for a reconsideration with the entity specified in the redetermination notice within 180 calendar days of the date the redetermination decision is received. At this level of appeal, there is no AIC requirement.

Slide

Five Levels of Fee-for-Service Appeals

- Third level – Hearing by Administrative Law Judge
- Fourth level – De Novo Review by Medicare Appeals Council
- Fifth level - Judicial Review

117

Notes

Instruction

•If a party is dissatisfied with the reconsideration decision (or Part B hearing officer decision) or if the adjudication period for the QIC to complete its consideration has elapsed, he or she can request a third level of appeal or a hearing before an Administrative Law Judge (ALJ). There is an AIC requirement, which will be adjusted annually in accordance with the percentage increase in the medical care component of the Consumer Price Index (CPI). A party must file a written request for an ALJ hearing within 60 calendar days of receipt of the QIC reconsideration notice or Part B hearing officer decision letter.

•The appellant or any other party to the ALJ hearing may request a fourth level of appeal, which is the De Novo Review by Medicare Appeals Council (MAC). The request for MAC review must be filed within 60 calendar days of receipt of the ALJ hearing decision or dismissal. At this level of appeal, there is no AIC requirement.

•A party to a MAC decision or an appellant who requests escalation of a MAC review may request a fifth level of appeal or judicial review if the case meets the AIC requirement. For actions filed on or after January 1, 2006, the AIC will be $1,090.00. The AIC amount is adjusted annually in accordance with the percentage increase in the medical care component of the CPI.

Slide

Reopening

- Remedial action taken to change a final determination or decision that resulted in overpayment or underpayment

118

Notes

Instruction

•A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. A reopening allows the correction of minor errors or omissions without initiating a formal appeal.

•If a claim is denied because a Contractor did not receive requested documentation during medical review and the party later requests a redetermination, the Contractor must process the request as a reopening. A Contractor must also process clerical errors such as mathematical or computational mistakes, inaccurate data entry, or denials of claims as duplicates.

Slide

Let's Review

- Under what circumstances are overpayments often paid?
- What are the 5 levels in the appeals process?

119

Notes

Instruction

• **Let's review the material we have covered in this chapter.**

?

• **Under what circumstances are overpayments often paid?**

•**Answer –**

•Duplicate submission of the same service or claim

•Payment to the incorrect payee

•Payment for excluded or medically unnecessary services

•Payment made as the primary insurer when Medicare should have paid as the secondary insurer

?

• **What are the five levels in the appeals process?**

• **Answer –**

•Redetermination by Contractor

•Reconsideration by Qualified Independent Contractor

•Hearing by Administrative Law Judge

•De Novo Review by Medicare Appeals Council

•Judicial Review

Slide

Post-Assessment Course Evaluation

- Thank you for your feedback

120

Notes

Instruction

•Are there any questions concerning the material we discussed today?

•I'm handing out the Post-Assessment(s)and Course Evaluation now. Please take the Post-Assessment(s) and mark your answers on the answer sheet(s) included in the package. After you have taken the Post-Assessment(s), please complete the Course Evaluation. The feedback that you provide will be used to continually improve the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program. Please hand in both the Course Evaluation and Post-Assessment(s) before you leave today's session. Thank you.

A

•<u>Note</u>: Each training module has a separate Post-Assessment package. Learners should receive the corresponding Post-Assessment package, depending on which training module(s) you have presented.

05 3 Hour Medicare Program Training Module

Post-Assessment